Park Side Medical Practice

Park View Centre, Chester Road North, Brownhills, WS8 7JB
Tel No 01543 728748 ***Dr D Jay***

NEW PATIENT QUESTIONAIRE
All Information provided is confidential.

We ask you to **FULLY** complete this form to ensure we have accurate details about your health prior to receiving your medical records from your previous GP.

CHECK LIST

- ☐ Fill in Registration Form, Health Questionnaire and Summary Care Record
- ☐ Sign the purple registration form
- ☐ If applicable - Supply proof of your medication
- ☐ If applicable – Supply a copy of your passport or proof of address
- ☐ Call the surgery in 3 days to check if you have been accepted.
- ☐ Once Accepted – Allow a further 2 days for you registration to activate
- ☐ Book a New Patient Health Check with the Nurse
  (Currently not required due to COVID-19)

Surname: **Forename:**	**Date of Birth:**
Address:	**Telephone No(s):**
NHS number (If known):	**Main Language Spoken:**
Email Address: **(By providing your email address, you are giving consent to receive emails from the practice)**	
Ethnicity: **White/British ☐ Black/British ☐ British/Asian ☐ Mixed British ☐** **Other Ethnic Group ☐ Please State:**	

Will you require access to our online appointment / prescription service? YES/ NO

Would you like to receive information or would like to join our Patient Participation Group? YES/NO

Meetings are held on a quarterly basis or you could become a virtual member

Carer: If you have a carer in place please state name address and telephone number.

If you are a carer please state here.

Medical History: Please list any serious illness, operations, ongoing problems & disabilities

Medication: Please list all regular medication including herbal remedies:

Allergies:

Have you ever had a TB vaccination (circle your answer)? YES - Approx When? NO

Height:	**Weight:**

Do you Smoke? YES ☐ NO ☐

If yes, would you like help to quit? YES ☐

How many units of alcohol do you drink per week?

1 unit = ½ pint of beer/lager/cider,1 small glass of wine, 1 small measure of spirits

Exercise

Activity Level: **Poor ☐** **Moderate ☐** **Fairly Active ☐** **Very Active ☐**

Family History:	
High Blood pressure YES/NO	Glaucoma YES/NO
Heart Disease YES/NO	Thrombosis YES/NO
Stroke YES/NO	Asthma YES/NO
High cholesterol YES/NO	Diabetes YES/NO
Other: (Please state)	
For Women only:	
Number of pregnancies	
Have you ever had a cervical smear? YES / NO If yes date of last smear:	
Have you ever had an abnormal smear: YES / NO	